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Cumulative Patient Profile

SUMMARY

Traditional record-keeping in family practice, based on the model of hospital charts, gives rise to some serious problems, illustrated in this article by a patient with an allergy to penicillin. The "cumulative patient profile," which separates pertinent information in the history from the continually updated information on short-term problems, can prevent repetitive history-taking and can make information easily accessible to busy physicians. (*Can Fam Physician* 1989; 35:1259–1261.)

RÉSUMÉ

La façon traditionnelle de tenir les dossiers en pratique familiale, basée sur le modèle des dossiers hospitaliers, soulève de sérieux problèmes, comme celui qu'illustre cet article portant sur un patient allergique à la pénicilline. Le «profil cumulatif du patient», qui sépare les renseignements pertinents à l'histoire de ceux qui sont continuellement tenus à jour sur les problèmes de courte durée, peut dispenser de refaire l'histoire et peut rendre les renseignements facilement accessibles aux médecins fort occupés.

Key words: cumulative patient profile, data base management, patient records

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A BIG PROBLEM with the family practice record is the recording of data base information: the past, family, drug, allergic, and social history. Undergraduate training can hinder more than it helps because it teaches from the model of the hospital chart, which is inappropriate for family practice because it relies on short-term memory. When patients are admitted to hospital, their past, family, drug, allergic, and social data base information is recorded on the same page as the presenting complaint, a useful practice because the history and results of physical examination are likely to be reviewed almost daily during the (usually) short hospital stay.

In family practice, however, the patient visits may be separated by long intervals and may involve many problems over many years, so that the information in the data base tends to disappear under a multitude of progress notes. This leads to oversights or wasteful repetition of history-taking.

The following is an example of what may result.

Case Illustration

One day a long-time patient who had a feverish cough visited his family physician. After examination and diagnosis, the physician was politely interrupted in the act of writing a penicillin prescription by the words, "Excuse me, Doctor. Can I have my chart for a minute?"

Taking the chart and a red pencil from the physician's desk, he wrote in block letters across the chart cover: ALLERGIC TO PENICILLIN!

He then tactfully went on to remind his physician how, on two occasions during his 18 years of attending the practice, an unpleasantly severe crop of hives had followed a single oral dose of penicillin. Review of the chart showed the progress notes written 14, and again six years earlier, had recorded these reactions.

This story illustrates several lessons, listed below, on taking patient history.

- Some clinical decisions need background information on past, family, drugs, allergic, or social history.
- This background information must be obtained and then recorded in a way that permits easy retrieval.

• If such information is recorded with progress notes, following the model of hospital-type charts, it tends to become lost over time and to require wasteful repetition.
• This information should be located beside the progress notes, but separately from them, on a part of the record that remains constant while the progress notes "progress." A suitable location is the chart cover.

Integrating these four lessons is the "cumulative patient profile" (CPP).[1]

Cumulative Patient Profile

Since its introduction some years ago, the CPP has revolutionized the record-keeping of family practitioners. The CPP provides easy access to background clinical information, but clearly separates the information from the intermittent, unpredictable, varied data of the progress note.

The family, social, past, allergic, and drug history and the preventive care plans are recorded in the CPP (Figure 1). It is attached to the inside front cover of the chart, facing the progress notes, which are attached to the back cover in reverse chronological order. When the chart is opened, the CPP on the left faces the most recent progress note on the right.

The two sides, the CPP and progress notes, together give what is functionally a one-page chart, recording the brief case history described above (Figure 1). Here the convenience and usefulness of the allergic history block, located always in the same quadrant of the CPP, is apparent. The allergic history is not only recorded, it is recorded always in the same place; so that, once obtained, it is readily available for repeated future reference, particularly as the progress note of the day is always written on the page opposite.

The simplicity of this arrangement is its special attraction. The clinical encounters typical of family practice are brief, and their brevity dictates brevity in the handling of the records. The user is always in haste, so the extraction and recording of data must not take more than a minute or two.

Teaching with the CPP

The defining characteristics of general practice are claimed to be continuity, comprehensiveness, and preventive care.[2-4] These are ideals rather than realities, but there is probably some justice in the claim.

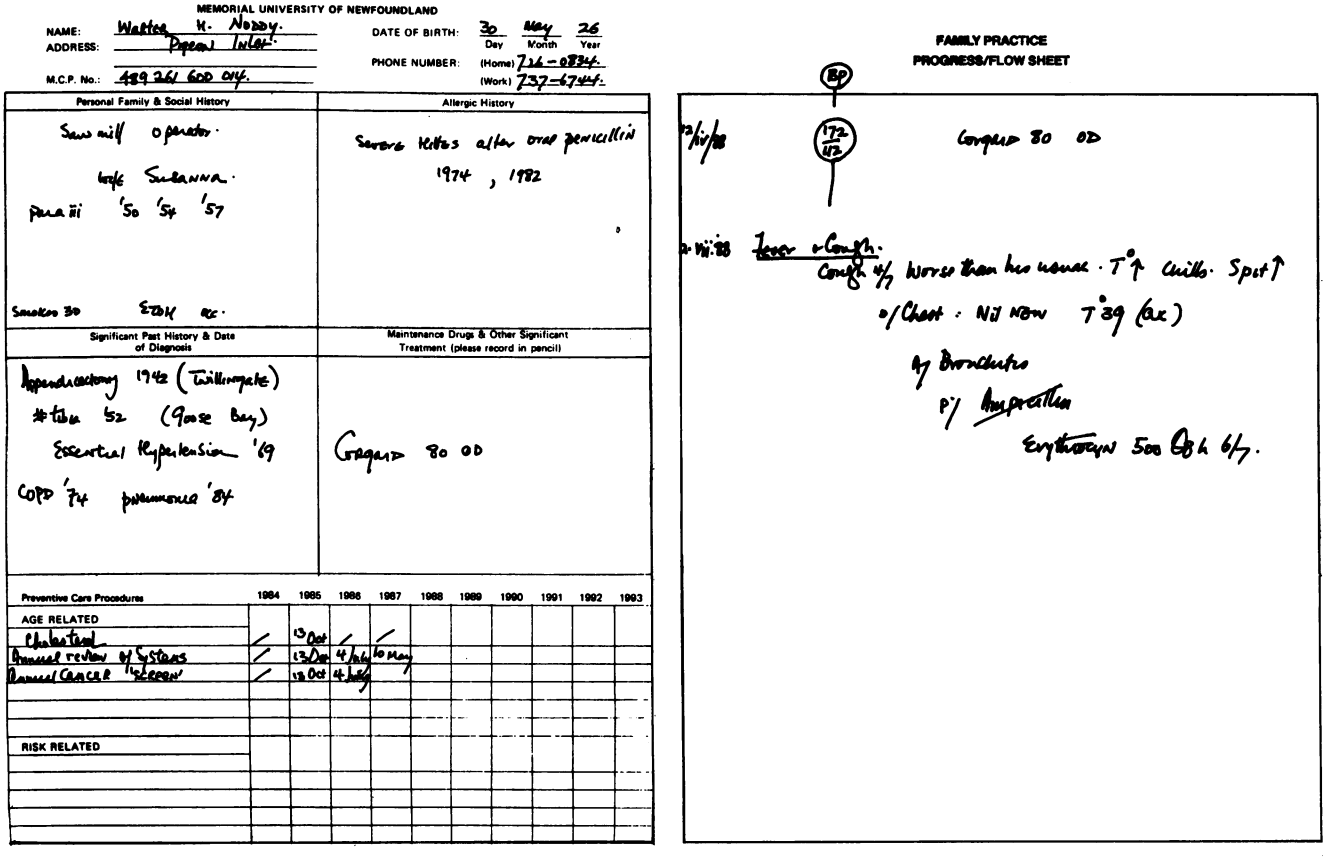
Continuity is the provision of suitable follow up for a given medical problem. Comprehensiveness is the concurrent provision of care for all other clinically significant problems. Preventive care is the provision of carefully selected preventive or screening medical manoeuvres that are judged to pass the test of cost-benefit analysis for the patient in question.

It is true that each of these three admirable qualities can be found in clinical disciplines other than general practice. But it is family practice that probably best promotes their development, through repeated encounters between physician and patient.

Innumerable repetitions of the episodic visit that characterizes family practice give rise to care that is continuous and comprehensive, as presenting complaints gradually become linked to earlier diagnoses. The broad caring relationship produces a concern for preventive health issues.

These processes of growth can be fostered and also taught by the right attitudes and skills in the physician,

Figure 1
Cumulative Patient Profile



and by one skill in particular, the ability of the physician to record the elements of continuous, comprehensive, and preventive care. In other words, the family practice chart should not be designed like a hospital chart, as an exhaustive record of some major illness lasting, on average, less than 10 days. Instead, the chart should be a time-unlimited record that displays the aspects of continuity, comprehensiveness, and preventive care that grow out of repeated doctor-patient encounters over a long period.

One way to do this is through the integration of the CPP and the progress notes (Figure 1). A re-examination of the patient's chart shows not only why he should not have a penicillin prescription, but also:

- that his feverish cough may be a complication of his COPD (raising the issue of continuity of care);
- that his hypertension was not well controlled at last visit and so needs review (raising the issue of comprehensiveness of care); and
- that a plan for annual cancer screening was made in 1983 but is now behind schedule (raising the issue of preventive care).

Conclusion

Family practice records have to be simple in design, so as to permit both rapid retrieval and rapid entry of data. They must also carry out several simultaneous functions expressing the continuity of, comprehensiveness of, and preventive care that are said to be defining characteristics of good general practice. A simple method of satisfying these complex requirements has been described, and is based upon the integration of the CPP with the traditional progress note.[1] ■

References

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